

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. **791**
Primary Registration District No. **1993**
(No. **St. John's Hosp**)

File No. **18060**
Registered No. **3353**
St. Ward)

2. FULL NAME

(a) Residence. No. **Christopher Ill**, St., **12** Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. **8** ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) **Married**

6a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Clifford White**

6. DATE OF BIRTH (MONTH, DAY AND YEAR) **Aug 25 - 1879**
7. AGE YEARS **48** MONTHS **7** DAYS **17** If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work **House Wife** (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) **Perry County Ill** (STATE OR COUNTRY)

10. NAME OF FATHER **J. B. Davis**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Ill** (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Francis Spargan**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **Ill** (STATE OR COUNTRY)

14. INFORMANT **Leonora Harris** (Address) **1731 Chicago Ave East St. Louis**

15. FILED **-7-1927** **Max C. Starnloff** REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **April 6 1927**

17. I HEREBY CERTIFY, That I attended deceased from **March 31**, 1927, to **April 6**, 1927, that I last saw her alive on **April 6**, 1927, and that death occurred, on the date stated above, at **2:30** p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute cardiac dilatation
123
95/119
8 hours (duration) **Intestinal fistula**
CONTRIBUTORY (SECONDARY) **7 years** (duration)

18. WHERE WAS DISEASE CONTRACTED **Christopher, Illinois** IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? **yes** DATE OF **April 1, 1927**

WAS THERE AN AUTOPSY? **No**

WHAT TEST CONFIRMED DIAGNOSIS? **Clinical and pathological** (Signed) **William H. Norton**, M.D.

April 7, 1927 (Address) **611 Metropolitan Bldg. St. Louis, Mo**

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL **Christopher Ill** DATE OF BURIAL **4-9-1927**

20. UNDERTAKER **Union Co-op Undertakers Co Christopher Ill** ADDRESS

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County.....
Towship.....
City.....*St. Louis* (No.....)

Registration District No.....*791*
Primary Registration District No.....*1603*

File No.....
Registered No.....*3353*
St..... Ward)

2. FULL NAME

Flora Mae Mills

(a) Residence. No..... St..... Ward.....
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX.....*D* 4. COLOR OR RACE.....*W* 5. SINGLE, MARRIED, WIDOWED OR
DIVORCED (write the word).....*M*

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR).....*Aug 25 - 1879*

7. AGE YEARS MONTHS DAYS If LESS than 1
47 *7* *11* day, hrs.
of min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or
particular kind of work.....
(b) General nature of industry,
business, or establishment in
which employed (or employer).....
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN).....
(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
(STATE OR COUNTRY)

14. INFORMANT.....
(Address)

15. JUL - 9 1921 *Flora Mae Mills*
FILED 19..... REGISTRAR

16. DATE OF DEATH (MONTH, DAY AND YEAR).....*Apr 6 1921*

17. I HEREBY CERTIFY That I attended deceased from.....
19....., 19.....
that I last saw h..... alive on....., 19....., and that
death occurred, on the date stated above at.....m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

CONTRIBUTORY.....
(SECONDARY).....
(duration).....yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.
19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state
(1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-13060